Providing Direction for the Mental Health Services Act (MHSA)
3 Year Integrated Plan and Annual Update

Background:

With the best of intentions, the Department of Mental Health (DMH) embarked on implementation of the Mental Health Services Act (MHSA) after Proposition 63 was approved by California's voters on November 4, 2004. This course of action led by DMH at the state-level reflected a new and unique process of implementing public policy through collaboration with passionate stakeholders and advocates with a range of knowledge and experience. All sought to develop the framework of the MHSA so that it would be a tool to transform the public mental health system. Collectively the following "strategic dimensions" were selected to be principles to embed into services and supports that would be funded by the MHSA:

a) Community collaboration
b) Cultural competence
c) Client/family driven mental health system for older adults, adults, and transition age youth and family driven system of care for children and youth
d) Wellness focus, which includes the concepts of recovery and resilience
e) Integrated services for clients and their families throughout their interactions with the mental health system

For county mental health directors, these "strategic dimensions" resonate with their own belief in what a "transformed" community-based public mental health system should consist of, if the depth of necessary resources to build, sustain and continuously improve such a system had been available. The opportunity to deliver services and supports with these embedded concepts and principles through the MHSA is more than inspiring, it is a responsibility. As local implementers of the Act, county mental health directors and their stakeholders must take a problem-solving approach that aims to implement the Act as intended, while also sustaining a system that is experiencing significant budget reductions and impacting available "core" services.

If there is unified agreement that the MHSA should function as the tool to implement these concepts and principles, the discussion must center on "transformation" and not "integration." The conversation is not about an "integrated" system but rather how to build a public mental health system that reflects the concepts and principles of "transformation" outlined above.

Key Recommendations:

1. The 3-year Integrated Plan should begin in FY 2009/10, and include all of the MHSA components in one streamlined and simplified plan.

2. The state's 3-year Integrated Plan guidelines should provide a simple framework for counties and their stakeholders to use as a community-driven roadmap for system transformation.

3. The submitted plans should plainly identify local strategic objectives and how they will be met through various MHSA services, supports, and investments.

4. Each county plan should create local accountability mechanisms for measuring outcomes, in addition to complying with any state oversight requirements specifically authorized by the Act.

5. Counties should define their own deliverables and indicators of success and system improvement within the "strategic dimensions" of transformation that are identified in the Act.

6. The MHSA sub-agreements will need to be re-drafted in FY 2009/2010 to comply with changes made, and to correlate with each county's performance contract.

7. The 3-year Integrated Plan must incorporate fiscal streamlining to increase timely cash flow (MHSA payments) to counties.

8. The 3-year Integrated Plan should reflect the established fiscal accountability for county plans already identified in the Act. Expenditure and revenue reports can reconcile the previous year's changes.

9. The 3-year Integrated Plan should acknowledge that program performance accountability already has existing statutory mechanisms at the local level through local mental health boards and commissions.

10. The 3-year Integrated Plan should recognize, reduce and/or eliminate reporting requirements that are duplicative, redundant and simply do not provide useful information.

Rationale for Change:

One of the choices made early on during implementation was to focus on funding services with the MHSA quickly, by building upon already proven effective models that reflect "transformation" principles and concepts. These services were system of care services for children, adults and older adults already established in the Welfare and Institutions Code (WIC). The Act's intent was clearly, to build upon what is already working. On the other hand, other components of the MHSA -- particularly the needed infrastructure to support the expansion of such services -- was not made available in the beginning. The negative result of staggered implementation has resulted in the inability of local communities to expand the intended services as quickly as had been hoped.

In the fervor to ensure that the concepts and principles of the MHSA be implemented, the initial guidelines designed by DMH became inflexible, restrictive, and incapable of facilitating a truly community-driven process. To make strides toward realizing "transformation" county by county, all components of the MHSA must be working in tandem as tools that provide opportunities to build effective programs that can also result in changing the overall delivery of public mental health services and supports, to the extent possible.

A recent performance audit of DMH's implementation of the MHSA from the Department of Finance's Office of State Audits and Evaluations (OSAE) is helpful in providing direction on how to make improvements that support transformation, and get needed resources into communities as soon as possible to address growing unmet need. The report claims that the Act has been

morphed into repetitive and redundant requirements that have became so labor intensive for counties that they have the potential to divert energy and resources away from developing transformational services and supports.

The direction provided from the OSAE report is straightforward:

- Implement the Act as it was intended
- Simplify the requirements and move toward performance measures and program monitoring efforts
- Promote effective communication and coordination among those involved in MHSA through the clarification of roles and responsibilities.

In light of these recommendations, and with the advantage of hindsight, DMH is committed to a new way of doing business with local public mental health systems. The State establishes a framework for implementation and provides oversight and evaluation, but local communities determine priorities and strategies, implement programs and manage funds. To shift to local accountability and support its effectiveness, the following is needed:

a) Empowered local stakeholders and communities that have access to information that tells them what is working and what is not.
b) Basic/fundamental accountability and performance indicators that counties -- in conjunction with their stakeholders -- can use to understand if they are achieving the goals they set out to achieve with the MHSA.

Counties and their stakeholders are eager to move toward system integration so that individuals and families are provided services and supports based on their needs, and not on which funding stream they are attached to (Realignment, Medi-Cal, MHSA, etc.). The MHSA was never intended to be a "categorical" set of programs. Rather, at the core of the Act is the vision of a community mental health system based on effective, efficient and high quality practices and strategies that are wellness-focused and include concepts of recovery and resilience. The remainder of this paper will identify how county mental health directors envision achieving this goal by using existing structures to course-correct implementation of the MHSA into a 3-year integrated plan, with annual updates that can include accountability mechanisms that assure that counties and their stakeholders are achieving system transformation.

Locally-Driven MHSA Implementation and Accountability

The Intent of the Act

The first step in providing direction for the 3-year integrated plan and annual update is to review the purpose and intent of the Act. Doing so will help re-direct focus on how to monitor the Act's implementation with strategies that best support achieving the goals inherent in the Act.

Section 3. Purpose and Intent
The People of the State of California hereby declare their purpose and intent in enacting this Act to be as follows:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.
(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.
(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.
(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

How to Achieve this Intent

In order to achieve the goals outlined above, the Act provides a roadmap by adding to and building upon existing statutory requirements in the California Welfare and Institutions Code (WIC) related to community mental health services. Existing system of care statutes already identify performance outcomes, performance contracting requirements and the role of county and state boards and commissions. A careful review of relevant MHSA WIC amendments and existing WIC sections offer a clear roadmap to locally driven MHSA implementation, outcomes reporting and overall mental health system integration. In addition, the hierarchy of reporting and accountability, starting at the local level through existing boards and commissions, to the state level through monitoring by the department and the Oversight and Accountability Commission, is quite clear. Following the roadmap that was so thoroughly examined in the drafting of the Act will assure efficiency and reinforcement of existing structures, consistent with the purpose and intent of the Act as stated in Section 3(e).

1. Developing Plans and Implementation

The stakeholder processes at the local and state levels are fundamental to achieving "transformation" that drives developing MHSA plans and monitoring their implementation. The MHSA, in addition to existing law regarding local mental health boards and commissions, provides direction regarding the important role stakeholders play in the overall movement of the public mental health towards transformation. CMHDA believes that the MHSA gives precedence to the local stakeholder process for plan development, and for ongoing plan oversight and performance. In short, the Act envisioned that if issues of question or concern arise with regard to a plan's content or performance, such issues would be vetted through the local review process that local mental health boards and commissions are required to conduct.

MHSA 5848(a) defines the role of local stakeholders in the development of initial plan and annual updates:

(a) Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, providers of service, law enforcement agencies, education, social services agencies and other important interests. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of such plans.

MHSA 5848(b) defines the role of local mental health boards and commissions, with a cross reference to existing WIC 5604, in conducting a public hearing regarding the plans and annual updates and recommendations to the local mental health department regarding revisions:

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft plan and annual updates at the close of the 30-day comment period required by subsection (a). Each adopted plan and update shall include any substantive written recommendations for revisions. The adopted plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

Existing WIC 5604 defines the composition and responsibilities of the local mental health boards/commissions. Section 5604(a) highlights a foundational composition that can support a consumer and family driven local system with counties encouraged to appoint individuals who have experience and knowledge of the mental health system, and who reflect the ethnic diversity of the client population in the county. Sections 5604.2 and 5604.3 list the duties of the local mental health board, including the review of the performance contract, advising the local mental health department and governing body (Board of Supervisors), and review and comment on performance outcome data and communicating findings to the California Mental Health Planning Council.

While the plan is locally developed through a stakeholder process that builds upon existing mechanisms of accountability, it is the role and responsibility of DMH, under MHSA Section 5848(c), to establish requirements for the content of the plans, which shall include a report on performance outcomes. As cited in the OSAE report, such requirements should eliminate repetitive reporting and redundant requirements, ask for broad concepts and not exact details, and place *"more reliance on the counties' expertise and the counties should be held accountable for the plans*" (p. 12).

The Act was specific in its direction as to how plans should be structured and submitted in Section 5847**,** *Relevant Sections include:*

(a) Each county mental health program shall prepare and submit a three year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission. The plan and update shall include all of the following:
(1) A program for prevention and early intervention in accordance with Part 3.6.
(2) A program for services to children in accordance with Part 4 to include a program pursuant to Chapter 6 of Part 4 of Division 9 commencing with Section 18250 or provide substantial evidence that it is not feasible to establish a wrap-around program in that county.
(3) A program for services to adults and seniors in accordance with Part 3.
(4) A program for Innovations in accordance with Part 3.2.
(5) A program for technological needs and capital facilities needed to provide services pursuant to Parts 3, 3.6 and 4. All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.
(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the Education and Training Programs established pursuant to Part 3.1.
(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults and seniors that it is currently serving pursuant to Parts 3 and 4 during years in which revenues for the Mental Health

Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(b) The department's review and approval of the programs specified in paragraphs (1) and (4) shall be limited to ensuring the consistency of such programs with the other portions of the plan and providing review and comment to the Mental Health Services Oversight and Accountability Commission.

(d) Each year the Department of Mental Health shall inform counties of the amounts of funds available for services to children pursuant to Part 4 and to adults and seniors pursuant to Part 3. Each county mental health program shall prepare expenditure plans pursuant to Parts 3 and 4 and updates to the plans developed pursuant to this Section. Each expenditure update shall indicate the number of children, adults and seniors to be served pursuant to Parts 3 and 4 and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(e) The department shall evaluate each proposed expenditure plan and determine the extent to which each county has the capacity to serve the proposed number of children, adults and seniors pursuant to Parts 3 and 4; the extent to which there is an unmet need to serve that number of children, adults and seniors; and determine the amount of available funds; and provide each county with an allocation from the funds available. The department shall give greater weight for a county or a population which has been significantly underserved for several years.

2. Building on Existing Structures to Assure Accountability

There are existing structures in place to hold counties accountable and locally monitor progress toward a transformed system. MHSA Section 5848(d) requires that services created will be included in the review of performance outcomes required by WIC Sections 5772(c)(2) and 5604.2 (a)(7). Existing WIC Section 5772 defines the authority of the Planning Council, including a review of performance outcomes data submitted to it by DMH and other sources. MHSA Section 5771.1 states that the members of the Oversight and Accountability Commission (OAC) are ex officio members of the Planning Council when the Planning Council is performing the duties defined in WIC 5772, therefore reviewing performance outcomes reported by the local mental health board/commission.

MHSA 5897(c) states that DMH shall implement the services through the mental health services performance contract, and references Part 2, Chapter 2, Sec. 5650 et seq. This existing Chapter states that the Board of Supervisors of each county or counties acting jointly shall adopt and submit a proposed annual performance contract for mental health services in a format and timeframe specified by DMH. Through existing WIC Section 5651, the contents of the contract are specified, with one requirement being that local mental health boards/commissions ensure citizen and professional involvement in the development of the plan. It also cross references Section 5604.2 regarding performance outcome requirements.

In addition, specific performance outcome measures for both the children's and adult systems of care are already in statute. We believe it was the intent of the Act use these outcomes as the foundation for which to gauge if and how the public mental health system is providing services that promote transformational concepts and principles. Over time, and as we learn through taking a quality improvement approach, revised measures may be called for, developed and implemented. For now, we must begin immediately to measure progress toward the Act's transformational goals, and performance outcomes in current statute are the place to start.

Conclusion:

It is appropriate that at this point in time -- nearly four years after the passage of Proposition 63 -- that stakeholders and responsible governmental entities practice continuous quality improvement of MHSA implementation. Doing this accurately will require assessing the impact of the decisions made to date -- regardless of intentions -- and measuring if and how the services and supports intended to be funded with MHSA funds are being implemented in counties statewide. The architects of the Act recognized that there was a strong existing system that would support locally driven implementation and accountability to build upon. This paper has identified such current mechanisms through WIC already existing and MHSA-added statute.

Both DMH and the OAC provide oversight, accountability and evaluation, as needed and when required. MHSA Section 5845(d)(7) states that the OAC may refer critical county performance issues to DMH, while DMH can request plans of correction when a county is not in compliance with its performance contract under MHSA Section 5897(d). Unfortunately, requirements developed for plan approval and the process of releasing MHSA resources to counties, according to the OSAE report, has resulted in *"untimely distributions that prevent counties from effectively planning and implementing programs and services for the mentally ill"* (p.15).

In summary, CMHDA contends that the already existing foundation of an accountability system in WIC should be maximized in order to shift back to local accountability for building a "transformed" system based on local need.